STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297036	A. BUILDING _____ B. WING _____	10/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALWAYS BETTER CARE	6950 VIA OLIVERO STE B4 LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey conducted at your agency from 10/5/10 through 10/8/10, in accordance with 42 CFR Part 484 - Home Health Services. The active census on the first day of the survey was 97. Fifteen clinical records were reviewed including four closed records. The sample included records from both the parent agency and branch office. Five home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000		
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by: Based on interview, record review, and document review, the agency failed to consistently implement its personnel policies in regards to employee orientation and skills competency. Findings include:	G 141		11/18/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 141	Continued From page 1 During review of personnel files on 10/7/10, the following were noted: Employee #7's date of hire was 8/31/10. There was no documentation the agency provided the employee with a general orientation to the agency or had assessed Employee #7's skills prior to providing direct patient care. On 10/7/10 in the afternoon, Employee #9 stated, Employee #7 had some orientation to the agency, but, "I haven't had time to document it." The agency's policy titled "Education and Training-General Orientation Policy No: 300.04" with a revised date of 02/21/08, read, "1. Administrator/Director of Operations (DOO) or designee will ensure all prerequisites for employment have been met prior to scheduling staff member for orientation. 2. New employees will receive general orientation within 30 days of hire ...A general Orientation checklist must be filled out and filed in employee file to show proof employee complete agency orientation." The agency's policy titled "Education Licensed Nurse Skills and Competency" with a revised date of 08/10/06, read, "1. Competency shall be determined through a combination of licensure, skills demonstration(s), and written examination(s). 2. The "Competency Checklist" shall be used for licensed staff in conjunction with routine Employee Orientation Program. 3. Upon hire, the licensed nurse shall complete the "Competency Checklist": a. The licensed nurse shall not accept any patient assignment that requires a Specialized skill for which he/she has not demonstrated competency. b. The director of	G 141		

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G 141	Continued From page 2 designee shall arrange for appropriate training and competency evaluations prior to assigning a nurse to a patient that requires "Specialized" skills. c. Training and competency shall be documented by written test and/or demonstration of the skill and placed in the employee's file. "	G 141		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to ensure a timely start of care assessment was competed for 1 of 15 sampled patients (Patient #15). Findings include: The agency's policy titled "Clinical Care-Patient Start of Care Assessment Policy No.: 200.30" with a revised date of 01/10/08, read, "An RN (Registered Nurse)/ PT (Physical Therapist)/ST (Speech Therapist) or designee will attempt to contact every patient the same day of referral to arrange for assessment visit date and time. The RN/PT/ST is to make initial assessment within 24-48 hours of referral." Patient #15 Patient #15 was referred to the agency on 9/17/10. Documentation in the patient's record indicated an RN made the initial assessment visit	G 157		11/18/10

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G 157	Continued From page 3 on 9/20/10, 72 hours after the referral. There was no documentation in the record Patient #15 requested a later visit date. On 10/8/10 at 1:05 PM, Employee #9 reviewed Patient #15's record and indicated there was no reason documented as to why an initial assessment visit was not made within 24-48 hours of the referral. Employee #9 stated, "I have to ask the nurse." On 10/8/10 at 1:15 PM, Employee #6 related she thought the referral came in late on a Friday and was told by the agency's intake person, the case did not have to be open over the weekend. During the interview, Employee #9 acknowledged only the physician or patient could request a delay of the initial assessment visit.	G 157		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the agency did not follow a plan of care for 4 of 15 patients (Patients #14, #3, #10 and #15). Findings include: Patient #14 Patient #14 was admitted to the agency on 08/30/10, with diagnoses that included chronic airway obstruction, diabetes, hypertension, and	G 158		11/18/10

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G 158	Continued From page 4	G 158		

muscle weakness. Upon admission, Patient #14's physician ordered skilled nursing visits to be completed twice per week for two weeks and once per week for one week.

A review of Patient #14's clinical record conducted on 10/06/10, indicated a Start of Care OASIS was completed by the nurse on 08/30/10. The next entry documented by the nurse was a "Physician's Order" dated 09/23/10. The document stated, "SN (skilled nurse) admitted Pt (patient) on 08/30/10 and was not seen again until 09/23/10 because the Pt fx (fractured) (right) ankle and HHA (Home Health Agency) was unable to get in contact (with) Pt during time period due to multiple MD visits and no returned calls ..." The document was signed by the nurse. The order was not signed by the physician, and there was no indication the document had been seen by the physician. No "Missed Visit" reports could be found.

Employee #9 was interviewed on 10/08/10 at 1:50 PM and indicated she was unable to find any Missed Visit reports in Patient #14's clinical record. Employee #9 also indicated the admission nurse reportedly completed Missed Visit reports but still had the reports in her possession. The Missed Visit reports were not in the chart and the physician had not been notified Patient #14 had not been seen as ordered.

Patient #3

Patient #3 was admitted 9/8/10, with diagnoses including chronic kidney disease, diabetes, and pressure ulcer to the lower back. Documentation in the record indicated the patient was unable to ambulate and required assistance to transfer to a

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G 158	Continued From page 5 wheelchair. 1. For the certification period of 9/8/10 through 11/6/10, the physician ordered nursing services one time a week for one week and two times a week for eight weeks. One of the duties of the nurse was to assess the patient's endocrine system on each visit for five visits. A review of the five nursing visits made from 9/6/10 through 9/24/10. revealed the Registered Nurse (RN) did not document a blood sugar (BS) result for four of the visits. On 10/7/10 at 2:10 PM, Employee #6 indicated the patient's wife performed the BS monitoring for Patient #3. The employee related she usually asked the patient's wife how the patient's BS was, but did not document any results. 2. For the same certification period, the physician ordered the services of the Home Health Aide (HHA) three times a week for nine weeks. There were no HHA notes in Patient #3's record. On 10/7/10 in the morning, Employee #9 indicated Patient #3 received help with personal care from a paid attendant so HHA services from the agency were not needed. Employee #9 related the physician should have been notified and the physician's order for HHA services should have been discontinued. 3. On 9/8/10, the physician ordered a "specialty mattress" for Patient #3 to aide with the healing of the patient's current pressure ulcer and to prevent further development of new pressure sores. During a home visit to Patient #3 on 10/6/10, with Employee #6, Patient #3's bed did not have any	G 158		

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speciality mattress overlay, nor did the mattress look to be other than a regular mattress for an adjustable bed. When asked if the mattress was a speciality mattress, Employee #6 stated, "It looks like just a regular mattress to me."

On 10/7/10 at 2:10 PM, Employee #6 reported she had looked at Patient #3's mattress closely after the visit on 10/6/10. The employee stated, "It's just a regular mattress."

Patient #10

Patient #10 was admitted on 9/10/10, with diagnoses including after care from a below the knee amputation, diabetes, and peripheral vascular disease. For the certification period of 9/10/10 through 11/8/10, the physician ordered nursing services one time a week for one week and two times a week for three weeks. One of the duties of the nurse was to asses the patient's gastrointestinal system (GI).

A review of the nursing notes for GI assessment for Patient #10 revealed the following:

9/13/10-bowel sounds were circled, but the documentation did not indicate if the bowel sounds were present or absent.

9/21/10-the nurse circled WNL (within normal limits) as the GI assessment.

Neither of the notes indicated if the patient had recent bowel movements. On 9/21/10, the Registered Nurse (RN) discontinued further nursing visits as Patient #10's "condition stabilized."

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On 9/25/10 at 9:45 PM, an RN made a visit to Patient #10. The RN documented, "PRN (as needed) visit as pt (patient) states she is unable to express bowel movement. Rectal exam performed. Lg (large) amt (amount) stool noted, able to remove only sm amt (small amount) stool. Unable to reach rest of it." Under GI assessment the nurse documented "Impacted." The RN further instructed the patient to go to urgent care if abdominal pain returned or the patient was unable to have another bowel movement.

The next nursing visit was on 9/27/10. A licensed practical nurse documented the patient required an emergency room visit over the weekend due to "sudden onset of abdominal pain and explosive diarrhea."

The nursing staff who visited Patient #10 failed to assess at each visit whether the patient had regular normal bowel movements.

Patient #15

1. Patient #15 was admitted on 9/20/10, with diagnoses including chronic ischemic heart disease, diabetes, and hypertension. For the certification period of 9/20/10 through 11/20/10, the physician ordered nursing services two times a week for two weeks and one time a week for one week. One of the duties of the nurse was to assess the patient's endocrine system on each visit. A review of the nursing visits made after the initial evaluation visit, revealed the Registered Nurse (RN) did not document a blood sugar (BS) result at any of the visits.

2. For the same certification period, the physician ordered the Medical Social Worker (MSW) to

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G 158	Continued From page 8 evaluate the patient. There was no documented evidence in Patient #15's record of an evaluation visit by the MSW. On 10/8/10 at 1:05 PM, Employee #6 (who was identified as responsible for Patient #15's care) was unaware the MSW had not evaluated the patient. Employee #6 stated when she had a referral to another discipline she would call and fax the information to the discipline ordered. There was no documented evidence a referral was made to the MSW. 3. During the entrance conference on 10/5/10, Employee #3 indicated the agency did not have a Speech Therapist (ST), but was actively recruiting for the service. On the initial referral the physician ordered the Occupational Therapist (OT) to evaluate the patient. There was no documentation in the record of an OT evaluation. On 10/8/10 at 1:05 PM, Employee #6 stated, "I know we don't have an OT right now so I couldn't make the referral." Employee #9 was present during the interview. Employee #9 stated, "We have an OT. We do not have an ST."	G 158		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to obtain physician orders for all visits made for 2 of 15 sampled patients (Patients #4 and #5).	G 165		11/18/10

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G 165	Continued From page 9 Findings include: Patient #4 Patient #4 was admitted to the agency on 3/17/10, with diagnoses including Foley catheter maintenance and diabetes. For the certification period of 9/13/10 through 11/11/10, the physician ordered nursing services one time a month for two months. A review of Patient #4's record revealed a Registered Nurse (RN) visited the patient on 9/24/10 and 9/26/10. There was no documented evidence in the patient's record of a physician order for the second visit in the month of September. Patient #5 Patient #5 was admitted on 8/26/10 with diagnoses including muscle weakness and depression. For the 60 day certification period beginning 8/26/10, the physician ordered nursing services one time a week for one week, three times a week for one week, two times a week for one week and one time a week for one week. A review of Patient #5's record revealed an RN visited the patient on 9/22/10 without a physician's order for the visit. On 10/8/10, at 4:20 PM, Employee #9 reviewed Patient #5's record and stated, "There is no order for that visit."	G 165		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS	G 166		11/18/10

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G 166	Continued From page 10 Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure physician orders were signed within 20 working days for 2 of 15 sampled patients (Patients #4 and #6). Findings include: The agency's policy titled "Office-Mailing Log/Tracking Physician Orders Policy No.: 900.23/2" read, ..."Company Policy is, all documents requiring Physician signature will be returned to office and placed in patient charts within 30 working days; earlier if required by State Regulation." (The Nevada Administrative Code 449.800 stipulated all medical orders must be signed by the physician within 20 working days of the verbal order). Patient #4 The start of care for Patient #4 was 3/17/10. Diagnoses included Foley catheter maintenance and diabetes. Patient #4's record contained a plan of care for the certification period of 3/17/10-5/15/10. The physician failed to sign the plan of care until 4/24/10. Patient #4's record contained a plan of care for	G 166		

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G 166	Continued From page 11 the certification period of 7/15/10 through 9/12/10. The physician failed to sign the plan of care until 8/19/10. Patient #6 The start of care for Patient #6 was 5/29/10. Diagnoses included urinary catheter maintenance and diabetes. Patient #6's record contained a plan of care for the certification period of 7/23/10-9/20/10. The physician failed to sign the plan of care until 10/6/10.	G 166		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure nursing services were provided in accordance with the plan of care for 6 of 15 sampled patients (Patients #14, #3, #10, #15, #4, and #5). Findings include: Patient #14 Patient #14 was admitted to the agency on 08/30/10, with diagnoses that included chronic airway obstruction, diabetes, hypertension, and muscle weakness. Patient #14's plan of care indicated skilled nursing visits were to be completed twice per week for two weeks and once per week for one week.	G 170		11/18/10

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A review of Patient #14's clinical record conducted on 10/06/10, indicated a Start of Care OASIS was completed by the nurse on 08/30/10. The next entry documented by the nurse was a "Physician's Order" dated 09/23/10. The document stated, "SN (skilled nurse) admitted Pt (patient) on 08/30/10 and was not seen again until 09/23/10 because the Pt fx (fractured) (right) ankle and HHA (Home Health Agency) was unable to get in contact (with) Pt during time period due to multiple MD visits and no returned calls ..." . The document was signed by the nurse. The order was not signed by the physician, and there was no indication the document had been seen by the physician. No "Missed Visit" reports could be found.

On 10/08/10 at 1:50 PM, Employee #9 stated she was unable to find any Missed Visit reports in Patient #14's clinical record. Employee #9 also indicated the admission nurse revealed she still had the Missed Visit reports in her possession. The Missed Visit reports were not in the chart and the physician had not been notified that Patient #14 had not been seen as ordered.

Patient #3

Patient #3 was admitted 9/8/10, with diagnoses including chronic kidney disease, diabetes, and pressure ulcer to the lower back. Documentation in the record indicated the patient was unable to ambulate and required assistance to transfer to a wheelchair.

1. For the certification period of 9/8/10 through 11/6/10, the physician ordered nursing services one time a week for one week and two times a week for eight weeks. One of the duties of the

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G 170	Continued From page 13 nurse was to assess the patient's endocrine system on each visit for five visits. A review of the five nursing visits made from 9/6/10 through 9/24/10. revealed the Registered Nurse (RN) did not document a blood sugar (BS) result for four of the visits. On 10/7/10 at 2:10 PM, Employee #6 indicated the patient's wife performed the BS monitoring for Patient #3. The employee related she usually asked the patient's wife how the patient's BS were, but did not document any results. 2. For the same certification period, the physician ordered the services of the Home Health Aide (HHA) three times a week for nine weeks. There were no HHA notes in Patient #3's record. On 10/7/10 in the morning, Employee #9 indicated Patient #3 received help with personal care from a paid attendant so HHA services from the agency were not needed. Employee #9 related the physician should have been notified and the physician's order for HHA services should have been discontinued. 3. On 9/8/10, the physician ordered a "specialty mattress" for Patient #3 to aide with the healing of the patient's current pressure ulcer and to prevent further development of new pressure sores. During a home visit to Patient #3 on 10/6/10, with Employee #6, Patient #3's bed did not have any speciality mattress overlay, nor did the mattress look to be other than a regular mattress for an adjustable bed. When asked if the mattress was a speciality mattress, Employee #6 stated, "It looks like just a regular mattress to me."	G 170		

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G 170	Continued From page 14 On 10/7/10 at 2:10 PM, Employee #6 reported she had looked at Patient #3's mattress closely after the visit on 10/6/10. The employee stated, "It's just a regular mattress." Patient #10 Patient #10 was admitted on 9/10/10, with diagnoses including after care from a below the knee amputation, diabetes, and peripheral vascular disease. For the certification period of 9/10/10 through 11/8/10, the physician ordered nursing services one time a week for one week and two times a week for three weeks. One of the duties of the nurse was to asses the patient's gastrointestinal system (GI). A review of the nursing notes for GI assessment for Patient #10 revealed the following: 9/13/10-bowel sounds were circled, but the documentation did not indicate if the bowel sounds were present or absent. 9/21/10-the nurse circled WNL (within normal limits) as the GI assessment. Neither of the notes indicated if the patient had recent bowel movements. On 9/21/10, the Registered Nurse (RN) discontinued further nursing visits as Patient #10's "condition stabilized." On 9/25/10 at 9:45 PM, a RN made a visit to Patient #10. The RN documented, "PRN (as needed) visit as pt (patient) states she is unable to express bowel movement. Rectal exam performed. Lg (large) amt (amount) stool noted, able to remove only sm amt (small amount) stool.	G 170		

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G 170	Continued From page 15	G 170		

Unable to reach rest of it." Under GI assessment the nurse documented "Impacted." The RN further instructed the patient to go to urgent care if abdominal pain returned or the patient was unable to have another bowel movement.

The next nursing visit was on 9/27/10. A licensed practical nurse documented the patient required an emergency room visit over the weekend due to "sudden onset of abdominal pain and explosive diarrhea."

The nursing staff who visited Patient #10 failed to assess at each visit whether the patient had regular normal bowel movements.

Patient #15

Patient #15 was admitted on 9/20/10, with diagnoses including chronic ischemic heart disease, diabetes, and hypertension. For the certification period of 9/20/10 through 11/20/10, the physician ordered nursing services two time a week for two weeks and one time a week for one week. One of the duties of the nurse was to assess the patient's endocrine system on each visit. A review of the nursing visits made after the initial evaluation visit, revealed the Registered Nurse (RN) did not document a blood sugar (BS) result at any of the visits.

Patient #4

Patient #4 was admitted to the agency on 3/17/10, with diagnoses including Foley catheter maintenance and diabetes. For the certification period of 9/13/10 through 11/11/10, the physician ordered nursing services one time a month for two months.

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G 170	Continued From page 16 A review of Patient #4's record revealed a Registered Nurse (RN) visited the patient on 9/24/10 and 9/26/10. There was no documented evidence in the patient's record of a physician order for the second visit in the month of September. Patient #5 Patient #5 was admitted on 8/26/10 with diagnoses including muscle weakness and depression. For the 60 day certification period beginning 8/26/10, the physician ordered nursing services one time a week for one week, three times a week for one week, two times a week for one week and one time a week for one week. A review of Patient #5's record revealed a RN visited the patient on 9/22/10 without a physician's order for the visit. On 10/8/10, at 4:20 PM, Employee #9 reviewed Patient #5's record and stated, "There is no order for that visit."	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on interview and record review, the Registered Nurse (RN) failed to re-assess the patient's nursing needs for 1 of 15 sampled patients (Patient #10). Findings include:	G 172		11/18/10

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G 172	Continued From page 17 Patient #10 Patient #10 was admitted on 9/10/10, with diagnoses including after care from a below the knee amputation, diabetes, peripheral vascular disease and left heel pressure ulcer. For the certification period of 9/10/10 through 11/8/10, the physician ordered nursing services one time a week for one week and two times a week for three weeks. Orders included the licensed nurse to assess the surgical incision from the amputation and provide and teach wound care to the left heel pressure ulcer. 1. On 9/21/10, the RN documented the left heel pressure ulcer had minimal serous drainage, the wound bed was dry and intact. There was no description of the right stump incision. On the visit, the RN discharged the patient from nursing services as Patient #10's "condition stabilized." On 9/24/10, a Licensed Practical Nurse (LPN) documented Patient #10 called the agency because the stump incision had opened and was draining a yellow drainage. The patient told the LPN the left heel pressure ulcer had re-opened. On 9/24/10, the LPN made a visit to Patient #10, who had been previously discharged from nursing services. The RN did not perform the initial re-visit to assess the patient's condition and initiate a new nursing plan of care. On 10/7/10 in the afternoon, Employee #9 indicated a RN should make the initial re-visit if a patient was discontinued from nursing services and developed problems.	G 172		

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G 172	Continued From page 18 2. For the certification period of 9/10/10 through 11/8/10, the physician ordered nursing services one time a week for one week and two times a week for three weeks. One of the duties of the nurse was to asses the patient's gastrointestinal system (GI). A review of the nursing notes for GI assessment for Patient #10 revealed the following: 9/13/10-bowel sounds were circled, but the documentation did not indicate if the bowel sounds were present or absent. 9/21/10-the nurse circled WNL (within normal limits) as the GI assessment. Neither of the notes indicated if the patient had recent bowel movements. On 9/21/10, the Registered Nurse (RN) discontinued further nursing visits as Patient #10's "condition stabilized." On 9/25/10 at 9:45 PM, a RN made a visit to Patient #10. The RN documented, "PRN (as needed) visit as pt (patient) states she is unable to express bowel movement. Rectal exam performed. Lg (large) amt (amount) stool noted, able to remove only sm amt (small amount) stool. Unable to reach rest of it." Under GI assessment the nurse documented "Impacted." The RN further instructed the patient to go to urgent care if abdominal pain returned or the patient was unable to have another bowel movement. There was no documented evidence the RN made a visit the following day to re-assess the patient's bowel status. There was no documentation the RN called the patient to	G 172		

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G 172	Continued From page 19 inquire on the patient's condition. The next nursing visit was on 9/27/10. A licensed practical nurse documented the patient required an emergency room visit over the weekend due to "sudden onset of abdominal pain and explosive diarrhea."	G 172		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure the physician was made aware of the condition and needs of 1 of 15 sampled patients (Patient: #14). Findings include: Patient #14 Patient #14 was admitted to the agency on 08/30/10 with diagnoses that included chronic airway obstruction, diabetes, hypertension, and muscle weakness. Upon admission, Patient #14's physician ordered skilled nursing visits to be completed twice per week for two weeks and once per week for one week. A review of Patient #14's clinical record on 10/06/10, indicated a Start of Care OASIS was completed by the nurse on 08/30/10. The next entry documented by the nurse was a "Physician's Order" dated 09/23/10. The	G 176		11/18/10

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G 176	Continued From page 20 document stated, "SN (skilled nurse) admitted Pt (patient) on 08/30/10 and was not seen again until 09/23/10 because the Pt fx (fractured) (right) ankle and HHA (Home Health Agency) was unable to get in contact (with) Pt during time period due to multiple MD visits and no returned calls ...". The document was signed by the nurse. The order was not signed by the physician, and there was no indication the document had been seen by the physician. No "Missed Visit" reports could be found. On 10/08/10 at 1:50 PM, Employee #9 stated she was unable to find any Missed Visit reports in Patient #14's clinical record. Employee #9 also indicated the admission nurse had completed the Missed Visit reports and still had them in her possession. The Missed Visit reports were not in the chart and the physician had not been notified that Patient #14 had not been seen as ordered.	G 176		
G 178	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel. This STANDARD is not met as evidenced by: Based on interview, record and document review, the agency failed to ensure the Registered Nurse (RN) supervised the Certified Nursing Assistants (CNA) for 2 of 3 patients receiving CNA services (Patients #4 and #2). Findings include: The agency's policy titled "Clinical Care-Aide Supervisory Visit Policy No.: 200.12A" with an	G 178		11/18/10

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G 178	Continued From page 21	G 178		

effective date of 04/09/97, read, "...1. If aide services are provided to a patient who is receiving skilled nursing, physical, occupational, and/or speech therapy services, an on-site visit to the patient's home must be made no less frequently than every two weeks to ensure the aide is properly caring for the patient...3. If the patient is receiving skilled nursing services, the registered nurse must perform the supervisory aide visit...4. Each supervisory aide visit must be completed on a Supervisory Review of Aide Performance form or in the designated area of the skilled note."

Patient #4

Patient #4 was admitted on 3/17/10, with diagnoses including Foley catheter maintenance and diabetes. For the certification period of 9/13/10 through 11/11/10, the physician ordered the services of the CNA three times a week for eight weeks to assist with personal care and light housekeeping.

Patient #4's record lacked documented evidence the RN performed on-site supervisory visits of the CNA.

On 10/7/10 in the morning, Employee #5 related it was the agency's policy to provide on-site supervisory visits of the CNA every 14 days.

Patient #2

Patient #2 was admitted to the agency with diagnoses that included pressure ulcer, hypertension, rheumatoid arthritis and below knee amputation.

On 07/20/10, Patient #2's physician ordered two

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G 178	Continued From page 22 Home Health Aide visits per week for five weeks. On 09/18/10, Patient #2's physician ordered two Home Health Aide visits per week for five weeks. Patient #2's nurse's notes revealed no supervisory visits by the Registered Nurse were documented. On 10/06/10, Employee #9 stated she could not locate supervisory notes in Patient #2's clinical record.	G 178		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on interview, record and document review, the agency failed to ensure the Registered Nurse (RN) supervised the Certified Nursing Assistants (CNA) for 2 of 3 patients receiving CNA services (Patients #4 and #2). Findings include: The agency's policy titled "Clinical Care-Aide Supervisory Visit Policy No.: 200.12A" with an effective date of 04/09/97, read, "...1. If aide services are provided to a patient who is receiving skilled nursing, physical, occupational, and/or speech therapy services, an on-site visit to the patient's home must be made no less frequently than every two weeks to ensure the aide is properly caring for the patient...3. If the patient is	G 229		11/18/10

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G 229	Continued From page 23 receiving skilled nursing services, the registered nurse must perform the supervisory aide visit...4. Each supervisory aide visit must be completed on a Supervisory Review of Aide Performance form or in the designated area of the skilled note." Patient #4 Patient #4 was admitted on 3/17/10, with diagnoses including Foley catheter maintenance and diabetes. For the certification period of 9/13/10 through 11/11/10, the physician ordered the services of the CNA three times a week for eight weeks to assist with personal care and light housekeeping. Patient #4's record lacked documented evidence the RN performed on-site supervisory visits of the CNA. A home visit was made to Patient #4 on 10/6/10, with Employee #8. When asked to see Employee #8's assignment sheet for Patient #4 the employee replied, "I don't carry assignment sheets with me, just my notes." The employee was unable to find a home care folder in the patient's home for a copy of the CNA assignment sheet. Patient #4 stated, "I haven't seen that folder for a while." On 10/7/10 in the morning, Employee #5 related it was the agency's policy to provide on-site supervisory visits of the CNA every 14 days. Patient #2 Patient #2 was admitted to the agency with diagnoses that included pressure ulcer, hypertension, rheumatoid arthritis and below knee	G 229		

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G 229	Continued From page 24 amputation. On 07/20/10, Patient #2's physician ordered two Home Health Aide visits per week for five weeks. On 09/18/10, Patient #2's physician ordered two Home Health Aide visits per week for five weeks. Patient #2's nurse's notes revealed no supervisory visits by the Registered Nurse were documented. On 10/06/10, Employee #9 was interviewed and stated she could not locate supervisory notes in Patient #2's clinical record.	G 229		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure clinical records were maintained in accordance with accepted professional standards for 6 of 15 sampled patients (Patients #1, #8, #3, #4, #6, and #10). Findings include:	G 236		11/18/10

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The agency's policy titled, "Office Policy-Time and Note Check-In Policy No. 900.52" with an effective date of 04/11/06, read, "All handwritten patient documentation and time sheets shall be turned in at the local agency on a weekly basis...Purpose:...2. To meet State and Federal guidelines regarding the need to have visit notes and physician orders in the patient record in a timely manner...Procedure:..5. After all notes have been checked in, the 60 sheets are to be balanced each week to ensure that physician orders and authorization has been followed. 6. After notes have been checked in, they are filed in appropriate patient chart."

Patient #1

Patient #1 was admitted to the agency on 09/30/10, with diagnoses that included cellulitis, diabetes, and multiple sclerosis. A Skilled Nursing Note dated 10/05/10, documented there were no concerns or questions at that time, and "follow up required for (treatment) of wound (and) PICC (Peripherally Inserted Central Catheter) line patency".

On 10/06/10, Patient #1 stated the nurse (Employee #6) who visited on 10/05/10, was unable to obtain a blood sample through his PICC line and Employee #9 would come to his home to obtain the blood sample.

On 10/06/10 at 4:30 PM, Employee #9 stated she visited Patient #1 that day to obtain the blood sample because Employee #6 was unable. Employee #9 was shown the Skilled Nursing Note which documented the 10/05/10 visit. Employee #9 indicated Employee #6 had not documented the inability to obtain a blood sample.

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G 236	Continued From page 26 Patient #8 Patient #8 was admitted to the agency on 09/03/10, with diagnoses that included toe amputation, diabetes, hypertension, and neuropathy. The clinical record was sent from the branch office to the parent office for review. There were no nursing visit notes in the record. The missing notes were faxed from the branch office to the parent office. Patient #3 Patient #3 was admitted 9/8/10, with diagnoses including chronic kidney disease, diabetes, and pressure ulcer to the lower back. Documentation in the record indicated the patient was unable to ambulate and required assistance to transfer to a wheelchair. For the certification period of 9/8/10 through 11/6/10, the physician ordered skilled nursing services one time a week for one week and two times a week for eight weeks. A review of Patient #3's record on 10/6/10, revealed the last nursing note filed in the patient's record was dated 9/22/10. The record was missing three nursing visit notes which made it difficult to assess the patient's condition and progress toward stated goals. Patient #4 The start of care for Patient #4 was 3/17/10. Diagnoses included Foley catheter maintenance and diabetes. Patient #4's record contained a plan of care for the certification period of 3/17/10-5/15/10. The	G 236		

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G 236	Continued From page 27 physician failed to sign the plan of care until 4/24/10. Patient #4's record contained a plan of care for the certification period of 7/15/10 through 9/12/10. The physician failed to sign the plan of care until 8/19/10. Patient #6 The start of care for Patient #6 was 5/29/10. Diagnoses included urinary catheter maintenance and diabetes. Patient #6's record contained a plan of care for the certification period of 7/23/10-9/20/10. The physician failed to sign the plan of care until 10/6/10. Patient #10 Patient #10 was admitted on 9/10/10, with diagnoses including after care from a below the knee amputation, diabetes, and peripheral vascular disease. For the certification period of 9/10/10 through 11/8/10, the physician ordered nursing services one time a week for one week and two times a week for three weeks. Patient #10's record was sent from the branch office to the parent office for review on 10/6/10. There were no nursing visit notes in the record. Seven nursing notes dating from 9/13/10 through 9/29/10, were faxed from the branch office to the parent office.	G 236		
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of	G 332		11/18/10

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	297036	A. BUILDING _____ B. WING _____	10/08/2010

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G 332	Continued From page 28 the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to ensure a Registered Nurse (RN) held an initial assessment visit within 48 hours of the patient's referral to the agency for 1 of 15 sampled patients (Patient #15). Findings include: The agency ' s policy titled " Clinical Care-Patient Start of Care Assessment Policy No.: 200.30 " with a revised date of 01/10/08, read, " An RN/ PT (Physical Therapist/ST (Speech Therapist) or designee will attempt to contact every patient the same day of referral to arrange for assessment visit date and time. The RN/PT/ST is to make initial assessment within 24-48 hours of referral." Patient #15 Patient #15 was referred to the agency on 9/17/10. Documentation in the patient's record indicated a RN made the initial assessment visit on 9/20/10, 72 hours after the referral. There was no documentation in the record, Patient #15 had requested a later visit date. On 10/8/10 at 1:05 PM, Employee #9 reviewed Patient #15's record and indicated there was no reason documented as to why an initial assessment visit was not made within 24-48 hours of the referral. Employee #9 stated, "I have to ask the nurse." On 10/8/10 at 1:15 PM, Employee #6 related she thought the referral came in late on a Friday and	G 332		

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G 332	Continued From page 29 was told by the agency's intake person the case did not have to be open over the weekend. Employee #9 acknowledged only the physician or patient could request a delay of the initial assessment visit.	G 332		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the agency did not ensure that a drug regimen review was correctly conducted. A review of medication records (MR) kept in the home and compared to review of clinical records at the agency revealed discrepancies for 5 of 15 sampled patients (Patients #1, #2, #12, #3, and #7). Findings include: The agency's policy titled "Clinical Care-Medications and Treatments Policy No: 200.18" with a revised date of 08/30/01, read, "...7. Skilled Nurses (SN) shall completely review all medications on initial evaluation visit and on recertification visits...8. Medication Record in patient chart and in home shall be updated any time new medication is ordered, or previous medication is discontinued..." Patient #1	G 337		11/18/10

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Patient #1 was admitted to the agency on 09/30/10 with diagnoses that included cellulitis, diabetes, and multiple sclerosis.

On 10/05/10, a home visit was made to Patient #1. Patient #1 was interviewed regarding his medications. Patient #1 displayed several medications he stored in the refrigerator that did not appear on his Medication Record. These medications included Novolog, Levemir, and Copaxone. Patient #1 stated he took between 20-35 units of Novolog, "about 50 units" of Levemir, and "20 milligrams a day of Copaxone."

No documentation of these medications or their intended dosages could be located in the clinical record.

Patient #2

Patient #2 was admitted to the agency with diagnoses that included pressure ulcer, hypertension, rheumatoid arthritis and below knee amputation.

On 10/05/10, Patient #2's clinical record was reviewed and a home visit was made to Patient #2. Patient #2 was interviewed about her current medications. Patient #2 displayed two medications she stated she took regularly but were not on her Medication Record. These two medications included Pantoprazole 40 milligrams to be taken by mouth once per day, and Sertraline 50 milligrams to be taken by mouth once per day.

On 10/06/10 at 10:10 AM, Employee #10 stated employees were unable to locate documentation regarding these two medications.

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G 337	Continued From page 31 Patient #12 Patient #12 was admitted to the agency on 09/23/10 with diagnoses that included diabetes and hypertension. On 10/07/10, a home visit was made to Patient #12. During the visit, Patient #12's medications were compared to her Medication Record. The Medication Record indicated Patient #12 received Bumetanide 0.5 milligrams by mouth each day. The prescription on the front of Bumetanide indicated each pill contained 1 milligram. Patient #12's spouse was interviewed. The spouse stated he prepared the medications and gave Patient #12 a Bumetanide 1 milligram pill each day. Patient #3 Patient #3 was admitted 9/8/10, with diagnoses including chronic kidney disease, diabetes, and pressure ulcer to the lower back. For the certification period of 9/8/10 through 11/6/10, the physician ordered nursing services one time a week for one week and two times a week for eight weeks. On 10/6/10, during a home visit, Patient #3's medicine bottles were matched with the MR from the patient's record in the agency office. The patient had the following medications in the home which were not on the Medication Record (MR). The patient's spouse verified the patient was using all the medications as listed: Rena-Vite one tablet every day; Iron 324 milligrams (mg) one tablet twice a day; Doc-q-lace 100mg one tablet twice a day; Glyburide 2.5 mg one tablet every day;	G 337		

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Nexium 20 mg one tablet every day; and,
Sliding Scale Humulin R insulin according to blood sugar results
--200-250 2 units
--251-300 4 units
--301-350 6 units
--351-400 8 units
--over 400 give 10 units and call the physician.

Patient #7

Patient #7 was admitted to the agency on 9/22/10, with diagnoses including care after a total hip replacement and muscle weakness. The initial assessment visit was performed by the Physical Therapist (PT) as the physician did not order skilled nursing services.

The PT documented the medications the patient was currently using on the MR. The following discrepancies were noted between what the PT had written on the MR and what was written on the plan of care (POC) sent to the physician for signature:

"Seroquol" 100 milligrams (mg) po (by mouth) was written on the MR. There was no frequency documented on the MR. The POC read, "Seroquel 100 mg Tab (tablet) every day orally:
"Tylonol" 4 every six hours as needed po was written on the MR. There was no dosage documented on the MR. The POC read, "Tylenol-Codeine #4 300 mg-60 mg every 6 hours orally as needed" and,
"Tigan 300 mg as needed po" was written on the MR. There was no time limit documented. The POC read, "Tigan 300 mg cap as needed orally."

On 10/7/10 in the afternoon, Employee #9 related

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G 337	Continued From page 33 she was responsible for reviewing the MR when the case was a therapy only case. When asked how the POC had medication spellings corrected, dosages, and frequency not written on the MR, Employee #9 stated, "I don't know." A policy in regards to medication regimen review responsibilities in therapy only cases was requested. The policy was not provided by the end of the survey.	G 337		
G 341	484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure a discharge Outcome Assessment Information Set (OASIS) comprehensive assessment was completed within 2 days of discharge for 1 of 4 sampled discharged patients (Patient #5). Findings include: Patient #5 Patient #5 was admitted on 8/26/10, with diagnoses including muscle weakness and depression. For the 60 day certification period beginning 8/26/10, the physician ordered nursing services one time a week for one week, three times a week for one week, two times a week for one week, and one time a week for one week. Patient #5 was discharged from the agency's services on 9/22/10.	G 341		11/18/10

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G 341	Continued From page 34 As of 10/8/10, there was no documentation in Patient #5's record the OASIS discharge assessment was completed. On 10/8/10 at 4:20 PM, Employee #9 reviewed Patient #5's record and stated, "There's no discharge OASIS."	G 341		
G 342	484.55(e) INCORPORATION OF OASIS DATA ITEMS The OASIS data items determined by the Secretary must be incorporated into the HHA's own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to incorporate the Outcome and Assessment Information Set data items into the agency's own assessment for all Medicare patients opened to agency services. Findings include: A review of the agency's initial assessment form revealed the form to be the Start of Care/Resumption of Care OASIS-C form OMB#0938-6760 Expiration date 7/31/2012, which the agency has altered, with an area at the bottom of each page for the patient's name. The agency has added some areas of non-OASIS assessment data under the following headings:	G 342		12/10/10

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G 342	Continued From page 35 Sensory Status Cardiovascular Endocrine Assessment Integumentary Status Respiratory Status Elimination Status Neuro/Emotional/Behavioral Status ADL/IADLs Musculoskeletal Assessment Page 16 of the assessment form was an agency form titled Skilled Nursing/Therapy note. An unaltered Start of Care/Resumption of Care OASIS-C form OMB#0938-6760 was 16 pages in length. The altered form used by the agency was 16 pages long including the agency's added assessment areas and the skilled nursing/therapy note page. On 10/7/10 in the afternoon, Employee #10 indicated the agency's corporation bought new software which would allow the corporation more input into creating forms.	G 342		